PRINTED: 7/26/2023 FORM APPROVED 2567-L

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395671			00	05/26/2023	
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902			STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE D		
F 0000	Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance Survey, and an Abbreviated Survey in response to a complaint completed on May 26, 2023, it was determined that Southmont of Presbyterian Seniorcare, was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long-Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long-Term Care Licensure Regulations.		F 0554				
SS=E							
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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		(XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER	ICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395671			<u></u>	05/26/2023	
SOUTHM	OVIDER OR SUPPLIER: ONT OF PRESBYTERIA: SE NUMBER: 422902	N SENIORCARE	STREET ADDRESS 835 SOUTH I WASHINGTO	MAIN STRE	ET		
(X4) ID PREFIX TAG	MUST BE PRECEE	NT OF DEFICIENCIES (EACH DE DED BY FULL REGULATORY O TIFYING INFORMATION)		THE VIDERS TEAM OF COR		OULD BE	(X5) COMPLETE DATE
F 0554	Continued from page 1			F 0554			
SS=E	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:		ons if the (ii), has		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the findings/conclusions set forth in the statement of deficiencies. The plan of correction has been prepared and/or executed solely because it is required by the provisions of Federal and State law.		Completion Date: 07/06/2023 Status: APPROVED Date: 06/12/2023
					Residents R16, R17, R39 an self-administration forms co on 5/22/23. Residents R16, I and R48 also have the prope physician order to self-admin Reeducation will be provide nurses by the nurse educator designee to ensure that resid who self-administer have the physicians order and form completed. An initial audit we completed of other residents ensure the proper form and physician order is completed self-administer by the DON designee. Audits will be con	mpleted R17, R39 r nister. d to the or ents e proper vill be to l if they or	

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· · · · · · · · · · · · · · · · · · ·		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395671			<u></u>	05/26/2023		
SOUTHMONT OF PRESBYTERIAN SENIORCARE 835 SOU		STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0554	Continued from page 2			F 0554				
SS=E	Production of the state of the			weekly times 4 and monthly to ensure residents who self-administer medications able to self-administer. Resu be brought to QAPI to deterr further auditing is necessary.	are still lts will mine if			
F 0600				F 0600				
SS=D								

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	` ' '			(X3) DATE SURVEY COMPLETED:	
		395671				05/26/2023	
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902		STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE DN, PA 1530	ET			
(X4) ID PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0600	Continued from page 3			F 0600			
SS=D	IDENTIFYING INFORMATION)			Resident R33 had no lasting effects from the incident on The employee and agency er involved were terminated/DI after the facility investigation completed. All allegations of and neglect are investigated facility. An initial audit will completed of any concern for received since 12/23/22 by the facility to ensure any that may risen to the level of abuse or were investigated by DON of designee. Reeducation will be completed with nursing staff nurse educator or designee of and neglect. Audits will be completed monthly times 3 of concern forms received by the facility to ensure any that may the level of abuse or neglect investigated by DON or designees. Results will be brought to Q determine if further auditing necessary.	12/23/22. mployee NR'd n was f abuse by the be orms he ay haven neglect or be f by on abuse of any he ay rise to are ignee. API to	Completion Date: 07/06/2023 Status: APPROVED Date: 06/12/2023	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				(X3) DATE SURVE COMPLETED:	(X3) DATE SURVEY COMPLETED:	
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F 0600	Continued from page 4			F 0600				
SS=D	28141 Case 2012 Capacitation of the services	iji ingghisiga ida san Ujekke jibynka sang	dentain a firm of the second s					
F 0610				F 0610				
SS=D								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		I 1 1		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
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SOUTHM	OVIDER OR SUPPLIER: ONT OF PRESBYTERIAN SE NUMBER: 422902	SENIORCARE	STREET ADDRES 835 SOUTH WASHINGT		ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI					(X5) COMPLETE DATE	
F 0610	Continued from page 5			F 0610			
SS=D	483.12(c)(2)-(4) Investigated Violation §483.12(c) In response to a exploitation, or mistreatment §483.12(c)(2) Have evident thoroughly investigated. §483.12(c)(3) Prevent furth exploitation, or mistreatment progress. §483.12(c)(4) Report the readministrator or his or her cother officials in accordance State Survey Agency, within incident, and if the alleged corrective action must be tated.	llegations of abuse, negret, the facility must: the that all alleged violates are potential abuse, neglet while the investigation sults of all investigation designated representative with State law, includin 5 working days of the violation is verified appice.	lect, ions are ect, n is in as to the e and to ing to the		Employee involved in this alwas removed resident R48 rereducation on abuse and ne was provided as a precaution Reeducation will be complet DON, ADON and unit mana NHA or designee on §483.12 response to allegations of ab neglect, exploitation, or mistreatment, the facility mu §483.12(c)(2) Have evidence alleged violations are thorou investigated. §483.12(c)(3) I further potential abuse, negle exploitation, or mistreatment the investigation is in progres §483.12(c)(4) Report the resinvestigations to the adminish his or her designated represe and to other officials in account State law, including to Survey Agency, within 5 word days of the incident, and if the alleged violation is verified appropriate corrective action be taken. An initial audit will completed to ensure this incidents a proper investigation. A will be completed monthly to	oom and glect n. ted with agers by 2(c) In puse, set: e that all aghly Prevent eect, t while ess. bults of all strator or entative ordance the State orking he in must ll be ident audits	Completion Date: 07/06/2023 Status: APPROVED Date: 06/12/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED:		
		395671		B. WING: 05/26/2023			
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN E NUMBER: 422902	SENIORCARE	STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
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F 0610	Continued from page 6		F 0610				
SS=D					any abuse allegations receive the facility to ensure the investigation is thorough by designee. Results will be bro QAPI to determine if further is necessary.	NHA or ught to	

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		(XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY
395671				A. BLDG: _ B. WING: _	_00	05/26/2023	
SOUTHM	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN SE NUMBER: 422902	SENIORCARE	STREET ADDRESS, 835 SOUTH M WASHINGTO	MAIN STRE	ET	,	
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY C FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0610	Continued from page 7			F 0610			
SS=D	Based on review of factorial facility investigative rewas determined that the investigate an allegation neglect for one of four. Finding include: Review of the facility properties of abuse/Neglect", Sectorial legation of abuse independent to describe exact words and include scene, positioning of attime etc. Review of the admission R48 admitted to the factorial Review of Resident R44 indicated a BIMS of the diagnoses of high the and diabetes (too much	eports and staff intere facility failed to the proof of mental abuse a residents (Resident policy "Corporate Coion III Response to icated that any with the the incident in fulle a graphic descript lleged victim, personal policy on 10/14/20. 18's MDS dated 5/13 irteen (cognitively in plood pressure, heart	view, it noroughly nd/or R48). ompliance esses will l, use ion of the nnel, and Resident 8/23, ntact) and t failure,				

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,		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395671		B. WING:		05/26/2023	
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902			STREET ADDRESS, 835 SOUTH N WASHINGTO	IAIN STRE	ET		
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F 0610	Continued from page 8		F 0610				
SS=D	Review of facility investigation and that the investigation and that the events on 9/23/23 should have been intertinvestigate Resident Rand/or neglect for one	esident R48 was not wering her and said in the said in the ser bed and old lancet due to sanitary reases was being abused. It is investigation indivolving all staff means not completed. The means statement from an another statement from the said of the surrounding the shown at 15/26/23, at 1:30 p.m. The surrounding the shown at	thappy it was bed staff cool is. The ons. icated that embers the facility one aide, garding wer. m. the tee taff who thoroughly ental abuse				

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■ * *		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
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F 0610	Continued from page 9			F 0610			
SS=D	R48).						
	28 Pa. Code:201.14(a)	Responsibility of lic	censee				
	28 Pa. Code 201.18 e (1) Management.						
	28 Pa. Code 211.10 c (d) Resident care pol	icies.				
	28 Pa. Code 211.12 (d))(1)(5) Nursing servi	ices				
F 0684				F 0684			
SS=E							

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			COMPLETED:		(X3) DATE SURVI COMPLETED:	EY	
		395671			00	05/26/2023	
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN SE NUMBER: 422902	SENIORCARE OF DEFICIENCIES (EACH DE	STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CORRECTIVE ACTION SHE	OULD BE	COMPLETE DATE
F 0684 SS=E	Continued from page 10 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundament treatment and care provided the comprehensive assessments ensure that residents reaccordance with professions comprehensive person-centeresidents' choices. This REQUIREMENT is not	I to facility residents. Ba ent of a resident, the fac eceive treatment and car al standards of practice, ered care plan, and the	ised on ility re in	F 0684	Residents R5, R67, R111 and did not have any ill effects as result of the physician not be notified. Reeducation will be provided to the nurses about physician notification and as residents for hyperglycemia blood glucose) and hypoglyc (low blood glucose) by nurse educator or designee. An init will be completed of current residents receiving blood glumonitor checks to verify that parameters are set and accurrent the EMAR by DON or designes. Audits will be completed we times 4 and monthly times 3 abnormal CBG levels to ensiphysician notification and monitoring was competed for readings over 400 or under 7 DON or designee. Results we brought to QAPI to determine further auditing is necessary.	s a eing e e ssessing (high cemia e tial audit e tate in gnee. eekly of 5 ure or 70 by rill be ne if	Completion Date: 07/06/2023 Status: APPROVED Date: 06/09/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395671		B. WING: _		05/26/2023	
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN SE NUMBER: 422902	SENIORCARE	835 SOUTH N WASHINGTO	1AIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0684	Continued from page 11			F 0684			
SS=E	Based on review of fact and staff interviews, it facility failed to notify decreased Capillary Bl and failed to assess resulting blood glucose) at glucose), for four of 13 R67, R111, and R123) Findings include: The Centers for Disease as: Diabetes Mellitus in health condition that at food into energy. Most broken down into sugar released into your blood sugar goes up, it signal insulin. Insulin acts like into your body's cells if diabetes, your body eit insulin or can't use the should. When there is not the signal insulin.	was determined that physicians of increa ood Glucose (CBG) idents for hyperglyc and hypoglycemia (log Residents (Residents a chronic (long-lass ffects how your body tof the food you eat ar (also called glucos odstream. When your last your pancreas to refe a key to let the blocor use as energy. If you her doesn't make entinsulin it makes as your pancreas to refer the company of t	abetes ting) y turns is e) and r blood elease od sugar you have ough well as it				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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F 0684	Continued from page 12			F 0684			
SS=E	responding to insulin, a your bloodstream. Ove health problems, such and kidney disease. Hy that occurs when blood normal, usually below (mg/dl). If left untreat weakness, confusion, usual even death. People be prescribed injectable maintaining acceptable Hyperglycemia, or high there is too much sugar when your body has too Hyperglycemia is bloomg/dL while fasting (mours, or a blood gluctone to two hours after hyperglycemia and it time, you can damage tissues and organs. Datincrease your risk of henerve damage may also	er time, that can cause as heart disease, visity poglycemia is a condiguose is lower that 70 milligrams per deed, hypoglycemia manconsciousness, arrive with Diabetes Melle insulin to assist in elevels of CBG's. In the blood glucose, occur in the blood. This had glucose greater that the eating for at least ose greater than 180 seating. If you have a suntreated for long your nerves, blood your nerves, blood your nerves, blood your nerves, blood your nerves and stroke eart attack and stroke	the serious on loss, addition an eciliter ay lead to hythmias itus may the surs when happens an 125 eight mg/dL periods of ressels, ls can e, and				

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 IF CONTINUATION SHEET Page 13 of 31

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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F 0684	Continued from page 13			F 0684			
SS=E	damage and non-healing wounds.						
	Review of the facility "Hypoglycemia" policy last reviewed 11/20/22, indicated the facility will						
	recognize, and treated properly, hypoglycemia is						
	defined as blood gluco absence of obvious sig						
	glucose will be rechect						
	document CBGs and to		s, unu to				
	A review of the facility "Change in Resident's Condition or Status" policy last reviewed 11/20/22, indicated the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status, if there is a need to alter the resident's medical treatment, and the Nurse Supervisor/Charge Nurse will record in						
	the resident 's medical changes in the resident status.						
	Review of the medical	record indicated Re	sident R5				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	LIA (X2) MULTIPLE CONSTRUCTION:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	, ,	395671		A. BLDG: _ B. WING: _		05/26/2023	
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F 0684	Continued from page 14			F 0684			
SS=E	was admitted to the fact diagnoses that included (progressive heart dise action of the heart must shortness of breath), are Review of Resident RS - a mandated assessme care needs) dated 3/30/remain current. Review of a physician indicated to inject 70 urinsulin) every 12 hours order dated 3/2/22, indicated per hypoglycer order dated 12/12/22, it (fast-acting insulin that minutes after injection keeps working for 2 to physician order dated 12/12/24, it (glucometer checks at be monitoring,	I diabetes, heart failed ase that affects pumpled cles causing fatigue and depression. It's Minimum Data Sent of a resident's ability 23, indicated the diabetes order dated 12/15/2 mits of Toujeo (a loss for diabetes. A physicated to check CBC mic protocol. A physicated to inject Not starts to work about peaks in about 1 hours) per sliding 12/28/22, indicated for	et (MDS lities and agnoses 1, ang-acting visician as sician avolog t 15 bur, and scale. A for				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE			.IA (X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
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F 0684	Continued from page 15			F 0684			
SS=E							
	Review of Resident R5	s's clinical record ele	ectronic				
	Medication Administra	ntion Record (eMAR	(3)				
	revealed that the resident's CBG's were as follows:						
	On 10/14/22, documented at 9:00 p.m., CBG was						
	noted to be 406. On 10/16/22, documen	ted at 9:00 p.m., CE	3G was				
	noted to be 476.	. 1 . 7 00 CD					
	On 10/21/22, documen noted to be 480.	ited at 7:00 a.m., CB	3 G was				
	On 10/23/22, documen noted to be 463.	ted at 9:00 p.m., CE	3G was				
	On 10/24/22, documen	ted at 9:00 p.m., CE	3G was				
	noted to be 519. On 10/25/22, documen	ted at 9:00 p.m., CE	3G was				
	noted to be 452.						
	On 10/27/22, documen	ted at 9:00 p.m., CE	3G was				
	noted to be 488.						
	On 10/31/22, documen	ted at 9:00 p.m., CE	3G was				
	noted to be 423.	-1 -4 0.00 ·· ·· · · CD4	7				
	On 11/8/22, documents noted to be 498.	ea at 9:00 p.m., CBC	j was				
	noted to be 476.						
				I	İ	J	

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER PLAN OF CORRECTION (POC) IDENTIFICATION NUMBE				(X2) MULTI	LE CONSTRUCTION: (X3) DATE COMPLETE			
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		395671		B. WING: _		05/26/2023		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
F 0684	Continued from page 16			F 0684				
SS=E	On 11/11/22, document noted to be 419. On 11/11/22, document noted to be 470. On 11/13/22, document noted to be 528. On 11/16/23, document noted to be 443. On 11/18/22, document noted to be 400. On 11/19/22, document noted to be 450. On 11/21/22, document noted to be 464. On 11/23/22, document noted to be 473. On 11/24/22, document noted to be 479. On 11/28/22, document noted to be 494. On 11/29/22, document noted to be 485. On 12/4/22, document noted to be 485. On 12/4/22, document noted to be 485.	tted at 9:00 p.m., CB tted at 7:00 a.m., CB tted at 9:00 p.m., CB	G was					

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395671		B. WING: _		05/26/2023	
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN E NUMBER: 422902	SENIORCARE	835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PROVIDER'S PLAN OF CORRECTION (EA PREFIX TAG CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			(X5) COMPLETE DATE	
F 0684	Continued from page 17			F 0684			
SS=E	noted to be 432. On 12/11/22, document noted to be 446. On 12/21/22, document noted to be 467. On 12/24/22, document noted to be 443. On 1/5/23, documented noted to be 437. On 1/7/23, documented noted to be 428. On 1/26/23, documented noted to be 447. On 1/29/23, documented noted to be 463. On 1/31/23, documented noted to be 463. On 1/31/23, documented noted to be 468. On 2/8/23, documented noted to be 513. On 2/9/23, documented noted to be 402. On 2/10/23, documented noted to be 402. On 2/10/23, documented noted to be 403.	ted at 7:00 a.m., CB ted at 7:00 p.m., CBG d at 9:00 p.m., CBG ed at 9:00 p.m., CBG ed at 9:00 p.m., CBG d at 9:00 p.m., CBG ed at 9:00 p.m., CBG d at 9:00 p.m., CBG	G was G was was was G was G was was was was				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	' '		PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:		
				A. BLDG: _				
		395671		B. WING: _		05/26/2023		
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN E NUMBER: 422902	SENIORCARE	835 SOUTH M WASHINGTO	IAIN STRE	ET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
F 0684	Continued from page 18			F 0684				
SS=E	On 2/10/23, documented noted to be 435. On 2/10/23, documented noted to be 411. On 2/11/23, documented noted to be 483. On 2/11/23, documented noted to be 535. On 2/11/23, documented noted to be 415. On 2/11/23, documented noted to be 460. On 2/17/23, documented noted to be 476. On 2/19/23, documented noted to be 482. On 2/26/23, documented noted to be 470. On 3/5/23, documented noted to be 470. On 3/5/23, documented noted to be 470.	ed at 9:00 p.m., CBC ed at 7:00 a.m., CBC ed at 12:00 p.m., CBC ed at 5:00 p.m., CBC ed at 9:00 p.m., CBC	G was					
	noted to be 445. On 3/14/23, documented noted to be 416. On 5/6/23, documented	-						

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/OF PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER				IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY	
		395671			_00	05/26/2023	
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN SE NUMBER: 422902	SENIORCARE	STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 19			F 0684			
SS=E	noted to be 412. On 5/6/23, documented noted to be 435. Review of Resident R5 progress notes indicate assessed for hyper-/hyl was not notified of abrilisted dates. Further review November 2022, revea p.m. "the glucometer resugar is "too high" to resugar is "too high" to resident work to the physician, glucose as ordered and in the resident 's record. The facility was unable to 1/7/23.	d the resident was no poglycemia, and the commal results on the view of the eMAR folled on 11/18/22, at 9 and 'HI' indicating ead. In dated 1/7/23, indicord/report to the physophyperglycemic port results of lab/dianursing will check that as needed, and to ded.	al ot physician above or 9:57 g that eated exician any ia, nursing agnostic blood ocument				

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· · · · · · · · · · · · · · · · · · ·		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395671		B. WING:		05/26/2023	
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902		SENIORCARE	STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 20			F 0684			
SS=E							
	Review of a clinical re-	cord indicated Resid	lent R67				
	was admitted to the fac	cility on 4/6/20, with	l				
	diagnoses that included diabetes, and depression.						
	Review of Resident Re	67 's MDS dated 2/2	8/23,				
	indicated the diagnoses	s remain current.					
	Review of a physician indicated to check bloc without coverage.						
	Review of Resident R6 resident's CBG's were		that the				
	On 1/16/23, documented at 7:00 a.m., CBG was noted to be 517.						
	On 4/2/23, documented noted to be 422.	d at 7:00 a.m., CBG	was				
	On 4/3/23, documented	d at 7:00 a.m., CBG	was				
	noted to be 412.	, cbG					
	On 5/16/23, documente	ed at 7:00 a.m., CB0	G was				
	noted to be 404						

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			COMPLETED:			EY
	395671				05/26/2023	
VIDER OR SUPPLIER: ONT OF PRESBYTERIAN E NUMBER: 422902	SENIORCARE	835 SOUTH M	IAIN STRE	ET		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
Continued from page 21			F 0684			
progress notes indicate assessed for hyperglyc documented, blood sugthe physician was not at A review of Resident Findicated nursing will aphysician any signs and hypo/hyperglycemia, and monitor/record/report at to the physician, nursing ordered and as needed, resident 's record. Review of a clinical rewas admitted to the fact diagnoses that included pressure, and depression.	d the resident was nemia, interventions of gar was not rechecked notified of abnormal R67's care plan dated assess/record/report d symptoms of gursing will results of lab/diagnong will check blood and to document in cord indicated Residual to the residua	ot were not ed, and results. 1 4/6/20, to the stic work glucose as the lent R111				
indicated the diagnoses	s remain current.					
	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN E NUMBER: 422902 SUMMARY STATEMENT MUST BE PRECEEDED IDENTIFY Continued from page 21 A review of Resident F progress notes indicate assessed for hyperglycodocumented, blood sughthe physician was not for the physician any signs and hypo/hyperglycemia, for monitor/record/report in to the physician, nursing ordered and as needed, resident 's record. Review of a clinical rewas admitted to the face diagnoses that included pressure, and depression. Review of Resident R1 Review of Resident R1 Review of Resident R1	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 21 A review of Resident R67's eMAR and clin progress notes indicated the resident was not assessed for hyperglycemia, interventions adocumented, blood sugar was not rechecked the physician was not notified of abnormal A review of Resident R67's care plan dated indicated nursing will assess/record/report physician any signs and symptoms of hypo/hyperglycemia, nursing will monitor/record/report results of lab/diagnot to the physician, nursing will check blood ordered and as needed, and to document in resident 's record. Review of a clinical record indicated Residuagnoses that included diabetes, high blood pressure, and depression.	A review of Resident R67's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, interventions were not documented, blood sugar was not rechecked, and the physician was not notified of abnormal results. A review of Resident R67's care plan dated 4/6/20, indicated nursing will assess/record/report to the physician any signs and symptoms of hypo/hyperglycemia, nursing will monitor/record/report results of lab/diagnostic work to the physician, nursing will check blood glucose as ordered and as needed, and to document in the resident 's record. Review of Resident R111's MDS dated 5/11/23, Review of Resident R111's MDS dated 5/11/23,	DENTIFICATION NUMBER: 395671 STREET ADDRESS, CITY, STATE, 2 835 SOUTH MAIN STRE WASHINGTON, PA 1530 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 21 A review of Resident R67's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, interventions were not documented, blood sugar was not rechecked, and the physician was not notified of abnormal results. A review of Resident R67's care plan dated 4/6/20, indicated nursing will assess/record/report to the physician any signs and symptoms of hypo/hyperglycemia, nursing will monitor/record/report results of lab/diagnostic work to the physician, nursing will check blood glucose as ordered and as needed, and to document in the resident 's record. Review of a clinical record indicated Resident R111 was admitted to the facility on 8/3/22, with diagnoses that included diabetes, high blood pressure, and depression. Review of Resident R111's MDS dated 5/11/23,	DENTIFICATION NUMBER: 395671 A BLDG:00	IDENTIFICATION (POC) A BLDG: 00

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED:	
	395671		_		05/26/2023	
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902			IAIN STRE	ET	1	
MUST BE PRECEEDI	ED BY FULL REGULATORY O		ID PREFIX TAG	CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETE DATE
Continued from page 22			F 0684			
* *						
400 notify WiD before means and at bedfine.						
Review of Resident R1	111's eMAR revealed	d that the				
resident's CBG's were	as follows:					
On 11/3/22, document noted to be 416.	ed at 12:00 p.m., CB	G was				
	ed at 12:00 p.m., CB	G was				
	ed at 12:00 p.m., CB	G was				
noted to be 550.	•					
	ed at 12:00 p.m., CB	G was				
noted to be 439.						
progress notes indicated the resident was not assessed for hypoglycemia, interventions were						
	NUMBER: 422902 SUMMARY STATEMENT MUST BE PRECEDIDENTI Continued from page 22 Review of a physician to inject Novolog insulation and the president's CBG's were On 11/3/22, document noted to be 416. On 11/8/22, document noted to be 533. On 11/9/22, document noted to be 550. On 12/5/22, document noted to be 439. A review of Resident I progress notes indicate assessed for hypoglyce documented, and the p	RECTION (POC) JOENTIFICATION NUMBER: 395671 VIDER OR SUPPLIER: DNT OF PRESBYTERIAN SENIORCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 22 Review of a physician order dated 8/9/22, it to inject Novolog insulin per sliding scale, 400 notify MD before meals and at bedtime. Review of Resident R111's eMAR revealed resident's CBG's were as follows: On 11/3/22, documented at 12:00 p.m., CB noted to be 416. On 11/8/22, documented at 12:00 p.m., CB noted to be 533. On 11/9/22, documented at 12:00 p.m., CB noted to be 550. On 12/5/22, documented at 12:00 p.m., CB noted to be 439. A review of Resident R111's eMAR and cl progress notes indicated the resident was massessed for hypoglycemia, interventions we documented, and the physician was not not	IDENTIFICATION NUMBER: 395671 VIDER OR SUPPLIER: DAT OF PRESBYTERIAN SENIORCARE ENUMBER: 422902 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 22 Review of a physician order dated 8/9/22, indicated to inject Novolog insulin per sliding scale, if over 400 notify MD before meals and at bedtime. Review of Resident R111's eMAR revealed that the resident's CBG's were as follows: On 11/3/22, documented at 12:00 p.m., CBG was noted to be 416. On 11/8/22, documented at 12:00 p.m., CBG was noted to be 533. On 11/9/22, documented at 12:00 p.m., CBG was noted to be 550. On 12/5/22, documented at 12:00 p.m., CBG was noted to be 439. A review of Resident R111's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, interventions were not documented, and the physician was not notified of	IDENTIFICATION NUMBER: 395671 STREET ADDRESS, CITY, STATE, R. 835 SOUTH MAIN STRE WASHINGTON, PA. 1530 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 22 Review of a physician order dated 8/9/22, indicated to inject Novolog insulin per sliding scale, if over 400 notify MD before meals and at bedtime. Review of Resident R.111's eMAR revealed that the resident's CBG's were as follows: On 11/3/22, documented at 12:00 p.m., CBG was noted to be 416. On 11/8/22, documented at 12:00 p.m., CBG was noted to be 533. On 11/9/22, documented at 12:00 p.m., CBG was noted to be 550. On 12/5/22, documented at 12:00 p.m., CBG was noted to be 439. A review of Resident R.111's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, interventions were not documented, and the physician was not notified of	IDENTIFICATION NUMBER: 395671 STREET ADDRESS, CITY, STATE, ZIP CODE: 83 SOUTH MAIN STREET WASHINGTON, PA 15301 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MOST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 22 Review of a physician order dated 8/9/22, indicated to inject Novolog insulin per sliding scale, if over 400 notify MD before meals and at bedtime. Review of Resident R111's eMAR revealed that the resident's CBG's were as follows: On 11/3/22, documented at 12:00 p.m., CBG was noted to be 416. On 11/8/22, documented at 12:00 p.m., CBG was noted to be 553. On 11/9/22, documented at 12:00 p.m., CBG was noted to be 550. On 12/5/22, documented at 12:00 p.m., CBG was noted to be 439. A review of Resident R111's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, interventions were not documented, and the physician was not notified of	IDENTIFICATION NUMBER 395671

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: (X3) DATE SUI COMPLETED: A. BLDG:00		(X3) DATE SURVI COMPLETED:	EY	
		395671			<u></u>	05/26/2023	
SOUTHMO	VIDER OR SUPPLIER: ONT OF PRESBYTERIAN SE NUMBER: 422902	SENIORCARE	835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 23			F 0684			
SS=E	Review of a clinical rewas admitted to the fact diagnoses that included depression. Review of Resident R1 4/18/23, indicated to in insulin that starts to we injection, peaks in about for 2 to 4 hours) insulin 400 call MD. Review of Resident R1 resident's CBG's were as CD 5/17/23, documented noted to be 69. A review of Resident F progress notes indicate assessed for hypoglyce documented, blood sugthe physician was not resident for the following the physician was not resident for the factor of the fa	cility on 4/17/23, with diabetes, heart fails 23's physician order agent Humalog (a fast ork about 15 minutes at 1 hour, and keeps in per sliding scale at 23's eMAR revealed as follows: ed at 8:00 a.m., CBC at 123's eMAR and clad the resident was not rechecked as not rechecked as not rechecked.	th ure, and r dated t-acting s after working and if over d that the G was inical ot were not ed, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395671			B. WING: _		05/26/2023		
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902			835 SOUTH N WASHINGTO	MAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 24			F 0684			
SS=E	the above listed date. A review of Resident R123's care plan indicated to give diabetes medication as ordered by doctor, and monitor/document for side effects and effectiveness. During an interview on 5/25/23, at 9:50 a.m. Licensed Practical Nurse (LPN) Employee E5 stated for residents with no blood glucose parameters and a CBG under 70 she would implement the hypoglycemic protocol, and over 380, she would call the doctor, document, and recheck the CBG in 15-30 minutes.						
	During an interview on 5/25/23, at 10:00 a.m. LPN Employee E8 stated for residents with no blood glucose parameters she would call the doctor is CBG was under 70 or over 400, she would notify the doctor, recheck the CBG in one hour, assess the resident, and document interventions and symptoms. During an interview on 5/25/23, at 10:06 a.m. Registered Nurse (RN) Employee E11 stated for						
	kegisterea Nurse (RN)	Employee E11 state	eu ior				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
395671			A. BLDG: _ B. WING: _	00	05/26/2023		
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902			STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 25			F 0684			
SS=E	residents with hyper-/h for parameters and if n would notify the docto 70 or over 400. She w minutes, assess the resi medical record. During an interview or Employee E14 stated s s orders, if no paramete the doctor for blood gli She would assess the re insulin, and document During an interview or Employee E15 stated f parameters for blood g doctor if under 70 or or glucose every 15 minute chart. During an interview or Employee E18 stated f	o parameters were liver if blood glucose would recheck in 15 - ident and document in 5/25/23, at 10:25 at the would check the ers ordered she would ucose under 60 or oversident, give the ord in the medical record in 5/25/23, at 10:30 at or residents with no lucose she would not ver 300, re-check that tes, and document in 5/10/23, at 9:22 a.r.	isted, she as under 30 in the .m. LPN doctor ' ld notify ver 400. ered dm. LPN stify the e blood in the .m., RN				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
395671			1	00				
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902			STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IVE ACTION SHOULD BE COMPLETE		
F 0684	Continued from page 26			F 0684				
SS=E	over 400 and no parameters she would call the doctor and document.							
	During an interview on 5/10/23, at 1:35 p.m. the Assistant Director of Nursing Employee E1 confirmed the facility failed to document hypo/hyperglycemic episodes, failed to follow hypoglycemic protocols, and failed to notify the MD of changes in condition for Residents R5, R67,							
	R111, and R123.							
	28 Pa. Code 201.18 (b)	(1) Management						
	28 Pa. Code 201.29(d)	Resident Rights						
	28 Pa. Code 211.10 (c)(d) Resident Care policies							
	28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services							
F 0698				F 0698				
SS=D								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			A. BLDG: _	IPLE CONSTRUCTION: (X3) DATE SURV COMPLETED:		EY	
395671			B. WING: _		05/26/2023		
NAME OF PROVIDER OR SUPPLIER: SOUTHMONT OF PRESBYTERIAN SENIORCARE STATE LICENSE NUMBER: 422902		835 SOUTH N WASHINGTO	IAIN STRE	ET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
F 0698	Continued from page 27			F 0698			
SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require diareceive such services, consistent with professional standards of practice, the comprehensive person-center care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:		-		Resident R29 has a dialysis take to dialysis. An initial au current dialysis residents will completed to ensure resident a dialysis book to take with the dialysis by DON or designed Reeducation will be completed the nurses by nurse educator designee to ensure the dialyst books are being filled out on as well as checking upon returnotes or changes. Audits will completed weekly times 4 ar monthly times 3 to ensure the dialysis books for all current residents are being filled out end by our nurses as well as checking upon return for not changes. Results will be brougher to determine if further is necessary.	dit of all l be s have them to e. ted with or ois our end urn for l be ad dialysis on our es or ught to	Completion Date: 07/06/2023 Status: APPROVED Date: 06/12/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395671				<u></u>			
SOUTHMONT OF PRESBYTERIAN SENIORCARE 8			STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0698	Continued from page 28			F 0698			
SS=D			he faulity The fait Thent Hone Hone Hone				
	301 ¥ 182, 50 ete: 27-1-1-2(0)	(d)(r)(s)(e) Hupsing	3.00				
F 0883				F 0883			
SS=D							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: (X3) DATE SUR COMPLETED: A. BLDG:00		'EY		
		395671		B. WING: 05/26/20			3	
SOUTHM	OVIDER OR SUPPLIER: ONT OF PRESBYTERIA: SE NUMBER: 422902	N SENIORCARE	835 SOUTH	SS, CITY, STATE, Z MAIN STRE TON, PA 1530	ET			
(X4) ID PREFIX TAG	SUMMARY STATEMEN MUST BE PRECEEI IDEN'		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI CORRECTIVE ACTION SI CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE		
F 0883	Continued from page 29		F 0883					
SS=D	Continued from page 29 483.80(d)(1)(2) Influenza and Pneumococcal Immunization §483.80(d)(1) Influenza and pneumococcal immunization §483.80(d)(1) Influenza. The facility must develop pol and procedures to ensure that- (i) Before offering the influenza immunization, each reor the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resid has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentate that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization or resident or the resident's representative receives educate regarding the benefits and potential side effects of the		ations o policies ch resident the ation esident ed; is the intation as ential aunization must n, each		Resident R29 received the pneumococcal immunization 5/24/23 as requested. Reedowill be provided to the nurs residents who request the pneumococcal immunization the pneumococcal immunization the pneumococcal immunization rurse educator or designee. Initial audit will be completed residents per month admitted 1/5/23-6/11/23 to ensure result who requested the pneumococcal immunization or designee. An audit therefore the pneumococcal immunization or designee weekly times monthly times 3 of 10 new admissions to ensure resided requested the pneumococcal immunization received the pneumococcal immunization received the pneumococcal immunization or designee. Results will be to QAPI to determine if fur auditing is necessary.	exaction sees that on receive exaction by An ted of 10 ted from sidents coccal on by DON after will ted and tents who all on by DON te brought	Completion Date: 07/06/2023 Status: APPROVED Date: 06/12/2023	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 395671			A. BLDG: _	PLE CONSTRUCTION: 00	(X3) DATE SURVE COMPLETED: 05/26/2023	ΞY	
			STREET ADDRESS, 835 SOUTH M WASHINGTO	IAIN STRE	ET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 0883	Continued from page 30			F 0883			
SS=D	(ii) Each resident is offered a pneumococcal immunization less the immunization is medically contraindicated resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentate that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refuse. This REQUIREMENT is not met as evidenced by:		the tation s tial				

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Certified End Page

SOUTHMONT OF PRESBYTERIAN SENIORCARE

STATE LICENSE NUMBER: 422902 SURVEY EXIT DATE: 05/26/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY